Outpatient Therapy Services under Medicare:

Background and Policy Issues

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Introduction

Rehabilitation or therapy services generally refer to any sole use or combination of physical therapy, occupational therapy, and speech/language pathology services. They often are post-acute services (furnished after a hospitalization or ambulatory surgical procedure) and can be supplied by many facilities in inpatient and outpatient settings. Medicare's Part B outpatient therapy coverage and payment rules apply when therapy is furnished to beneficiaries on an outpatient basis— that is, these policies are distinct from the coverage and payment policies that apply when therapy is furnished under Medicare's inpatient hospital, skilled nursing facility (SNF), and home health benefits. Medicare also pays for therapy furnished by therapists in private practice.

Medicare regulations allow several provider types to furnish outpatient therapy, including hospitals, primary care hospitals, rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs), SNFs, home health agencies (to non-home bound patients), public and private clinics, public health agencies, hospices, and others under contract to these providers (such as private practice therapists).[1] In terms of Medicare outlays and patient volume, the most common settings are hospital outpatient departments (OPDs), rehabilitation agencies, and SNFs. (The latter can furnish "Part B therapy", or therapy paid under the outpatient therapy rules, to patients who do not meet Medicare's SNF Part A criteria, such as the prerequisite hospital stay, and to other beneficiaries who are not inpatients at the SNF.)

The Balanced Budget Act (BBA) of 1997 represented the largest package of changes to the Medicare program since its inception. Many of the changes were a response to a decade of double-digit growth in Medicare's post-acute care outlays. The most well-known of the BBA-mandated post-acute provisions required the Health Care Financing Administration (HCFA) to implement prospective payment systems (PPSs) for SNFs, home health agencies, and rehabilitation facilities (free-standing hospitals and units of acute care hospitals). Seemingly less noticed at the time, the BBA also modified outpatient therapy coverage and payment policies. The BBA placed outpatient therapy under the same coverage and payment rules that had governed private practice therapists for several years. Specifically, the law replaced cost-based payments for outpatient therapy with payments under Medicare's physician fee schedule, and imposed annual, dollar-based coverage limits for outpatient therapy. Over the next year or two, the imposition of coverage limits became hotly debated. Ultimately, the Balanced Budget Refinement Act of 1999 (BBRA) placed a moratorium on the limits (regarding therapy from outpatient therapy providers as well as private practice therapists) during 2000 and 2001.

[1] SSA 1861(p); SSA 1861(u).

The BBA also indicated that future outpatient therapy coverage or payment should be determined by a patient classification system rather than by dollar limits. To that end, the BBA requires HCFA to submit a report to Congress by January 2001 with recommendations concerning outpatient therapy policies based on classification of individuals by diagnostic category and prior use of inpatient and outpatient services. The BBRA added a few related provisions— it requires that functional status be considered in the design of a new outpatient therapy policy; a discussion of methods be included to help ensure appropriate use of outpatient therapy; and outpatient therapy utilization patterns be studied during the period from 1998 through 2000.

To help meet these requirements, HCFA contracted with The Urban Institute in summer 2000 to provide a series of three reports. This first report describes outpatient therapy services and providers, and overviews the Medicare post-acute care landscape preceding the BBA. As requested, to help broaden our understanding of these services the report also describes outpatient therapy coverage and payment policies of several private insurers, outpatient therapy guidelines developed by medical management organizations, and outcome tracking systems used by some outpatient therapy providers. The report then discusses several alternatives to the BBA coverage limits that Medicare could apply in the immediate future to help curb its outpatient therapy outlays. These options include various fee schedule mechanisms, modified applications of dollar coverage limits, and activities such as pre-payment outpatient therapy review by fiscal intermediaries. Longer-range options that involve an outpatient therapy patient classification scheme are also discussed. The longer-range options will require extensive, additional analyses of the longer episodes of care (including outpatient therapy and relevant prior care) of Medicare beneficiaries. The report concludes by outlining the Urban Institute's work plan regarding two empirical reports, which will follow in middle 2001 and early 2002, on Medicare outpatient therapy patients, their patterns of care, and payments.

Therapy coverage policies under Medicare

Medicare coverage policies for therapy are broadly stated, and apply across therapy and provider types. The rules state that therapy must be appropriate and effective for a patient's condition; it must be expected to improve the patient's condition relative to the duration and extent of the therapy; it must be reasonable in amount, frequency, and duration; and it must require a skilled professional (HCFA, 1998b). Medicare does not cover therapy when it is performed repetitively to maintain a level of function (maintenance therapy); when a patient's restoration potential is insignificant in relation to the therapy required to achieve such potential; when it has been determined that the treatment goals will not materialize; or when the therapy performed is considered to be a general exercise program (although Medicare does cover establishment of a maintenance therapy program). Regarding outpatient therapy services specifically, Medicare requires that a patient be under the care of a physician and that outpatient therapy be part of a written treatment program that is reviewed every 30 days by a physician.

Therapies included under these outpatient therapy rules are physical therapy, occupational therapy, and speech/language pathology services. Physical therapy aims to

optimize patients' ability to move and function independently. It focuses on alleviating impairments and functional limitations through a variety of therapeutic interventions, or modalities. Common interventions include therapeutic exercise (such as strengthening and mobility exercises), customization and training in the use of prosthetic devices and equipment, and wound management. A typical example of physical therapy is gait training on ramps, stairs, and curbs for patients whose walking ability was impaired by injury or illness (APTA, 1998). Physical therapy accounts for about 70 percent of Medicare's outpatient therapy expenditures. (See Table 1.) Occupational therapy primarily focuses on compensatory techniques to improve a patient's ability to complete activities of daily living (ADLs) independently. Therapy can include developing and training in the use of assistive or orthotic devices; and adapting environments and processes to enhance functional performance. Two examples include teaching a patient who has lost the use of an arm how to prepare food and cook with one hand and training a patient in the use of an assistive device that would enable him to hold a utensil and feed himself independently (AOTA, 1994). Occupational therapy accounts for about 20 percent of Medicare's outpatient therapy outlays. Speech/language pathology services are aimed at helping patients restore communication skills that have been hindered as a result of surgery, injury, or illness (such as, commonly, stroke). These services include helping patients who have difficulty swallowing; helping individuals with articulation disorders to learn proper production of speech sounds; helping patients with aphasia (that is, patients with partial or complete loss of the ability to communicate or comprehend spoken or written language) relearn speech and language skills; and selecting communication systems (such as voice synthesizing computers and communication boards) for people with severe speech problems. Speech/language pathology services account for about 10 percent of Medicare's spending on outpatient therapy.

Outpatient providers of therapy

Medicare rules state that outpatient therapy providers must offer an adequate "integrated multidisciplinary therapy program" that includes physical, occupational, and speech therapy, as well as social or vocational adjustment services when needed. An "adequate" program includes therapeutic exercise; alternative modes of therapy delivery including heat, cold, water, and electricity; and tests and measurements of strength, balance, endurance, range of motion, and ADLs. Facilities, equipment, and personnel are considered to be adequate if they can support this type of program. Providers also must have a physician available on call to furnish emergency medical care (HCFA, 1998b). State agencies survey new facilities to verify compliance with Medicare's certification requirements for facilities.

A number of provider types may deliver therapy under the outpatient therapy benefit. As shown in Tables 1 and 2, the largest providers (in terms of Medicare expenditures, patient volume, and provider supply) are the outpatient departments of acute care hospitals and rehabilitation specialty hospitals, as well as rehabilitation agencies and SNFs. A smaller provider group is CORFs. A negligible share of outpatient therapy is furnished by home health agencies, public health agencies, rural health clinics, hospices, and federally qualified health centers. Therapists in private practices also provide outpatient therapy. Although Medicare does not categorize them as "outpatient", or facility-based, providers, we will include these therapist

services in our analyses because the BBA placed both outpatient therapy providers and private practice therapists under the same coverage and payment rules.

Hospital outpatient departments

According to the American Hospital Association's annual survey of hospitals, 80 percent of the nation's community hospitals furnish outpatient therapy services (AHA, 2000). Another 200 rehabilitation specialty hospitals also typically furnish the range of outpatient therapy services**.** A recent analysis of beneficiary access to hospital OPDs reported that, overall, 95 percent of beneficiaries live in counties in which there is at least one hospital OPD that furnishes outpatient therapy. And, 98 percent of those in urban counties have access to these OPDs; 86 percent of those in rural counties have access to these OPDs (GAO, 1999).

Rehabilitation agencies

According the Medicare's on-line survey and certification reporting system (OSCAR), the number of Medicare-certified rehabilitation agencies grew, on average 9 percent annually during the 1990s, from 1,241 to 2,933. The growth rate accelerated to 15 percent annually in the mid-1990s, in part as some private practice therapists recertified as rehabilitation agencies during that time.

Although rehabilitation agencies are found throughout the country, 25 percent (734) are located in HCFA's Atlanta region, which encompasses eight southeastern states. Another 20 percent (587) are in the Chicago region, which comprises six upper midwest states. (See Table 2.) The shares of rehabilitation agencies in those regions are large relative to the areas' numbers of Medicare beneficiaries— about 15 percent of beneficiaries reside in the Atlanta region and approximately 14 percent live in the Chicago region. (See Appendix A for a list of states and territories by HCFA region assignment.)

The size of rehabilitation agencies ranges greatly, from local agencies that employ a small number of therapists to national companies that operate in many market areas. Smaller rehabilitation agencies generally are owned by therapists and most (93 percent) are proprietary. Agencies furnish outpatient therapy directly to patients, but many also contract their services to other institutional providers, such as SNFs. Note that such contracted services are billed under the appropriate Medicare benefit. In SNFs, for example, rehabilitation agencies can furnish contracted therapy services to Part A or Part B patients, and those services would be billed under the appropriate SNF Part A benefit or Part B benefit. [2]

Comprehensive outpatient rehabilitation facilities

CORF services were added as a Medicare benefit in 1982, as required by the Omnibus Reconciliation Act of 1980. CORFs may furnish a broader and more intense array of services

[2] S.S.A. 1861(p).

and therapy than those offered by rehabilitation agencies. They are sometimes known as "day hospitals", as patients may spend several hours during the day receiving care at a CORF.

Unlike rehabilitation agencies, CORFs must furnish physician services and social or psychological services, as well as physical therapy. In addition, CORFs may provide occupational therapy, speech/language pathology services, respiratory therapy, nursing services, drugs and biologicals that cannot be self-administered, prosthetics and orthotics, and home evaluations. CORFs initially were required to furnish all services on site, though this requirement was removed in 1987 so that CORFs could provide physical, occupational, and speech therapy at any location, including patients' homes.[3] In contrast with other outpatient therapy services, CORF services must be performed by or under the supervision of a physician, a facility physician must review the treatment plans, and the plans must be recertified every 60 days (rather than 30 days).[4]

Compared with the supply of other post-acute providers, the number of CORFs is quite small. (Some outpatient therapy providers have commented that the popularity of rehabilitation agencies relative to CORFs is partly due to the CORF physician supervision requirement.) The CORF supply grew about 20 percent annually, from 61 in 1985 to 589 by 1998. However, the number of CORFs actually declined in 1999, to 516. Most of that decline (75 percent) occurred in two states— Florida and Pennsylvania. In contrast, growth in the number of CORFs was particularly focused in HCFA's Atlanta region throughout the 1990s, and that provider concentration remains today. Indeed, Florida alone is home to 35 percent of the nation's current CORF supply. Compared with rehabilitation agencies, CORFs are more likely to be owned by hospitals or other entities that own multiple health care facilities. About 70 percent are proprietary.

Skilled nursing facilities

Skilled nursing facilities include mainly hospital-based units and free-standing facilities.[5] In the 1990s, the number of SNFs rose about 6 percent annually, to over 16,000 facilities by 1999. The vast majority of Medicare therapy services furnished by SNFs are to beneficiaries receiving care under the SNF Part A benefit. Accordingly, these therapy services are reimbursed

[3] 42 CFR 485.50.

[4] "Facility physician" services include consultation and medical supervision of non-medical staff, review of treatment plans, and other administrative activities. Diagnostic and therapeutic services furnished to an individual patient are not considered facility physician services— such services are considered physician (rather than CORF) services and are reimbursed according to the physician fee schedule.

[5] Designated rural hospitals can furnish SNF care without having to have dedicated SNF units. This "swing-bed" program was created in the early 1980s to address the shortage of nursing home beds in rural areas and the low occupancy rates in many rural hospitals.

under Medicare's resource utilization groups (RUGs) prospective payment system implemented in July 1998 for SNF Part A services.[6]

Under Medicare's Part B outpatient therapy policies, however, skilled nursing facilities can furnish outpatient therapy to inpatients who do not meet Medicare's SNF Part A coverage criteria (such as the prior hospital stay), to inpatients who have exhausted their SNF Part A benefits, and to other patients on an ambulatory basis (that is, to beneficiaries who are not inpatients, or residents, at the facility). These therapy services are reimbursed under Medicare's fee schedule and were subject to the BBA-mandated outpatient therapy coverage limits. As explained further below, the coverage limits, as temporarily implemented in 1999, affected SNF patients— particularly inpatients who exhausted their SNF Part A benefit or who were not eligible for a Part A stay— more stringently than all other patients receiving outpatient therapy.

Therapists in private practice

The Medicare Part B benefit also allows for therapy services as furnished by physical and occupational therapists in independent (private) practice.[7] As mentioned, Medicare's coverage and payment rules for private practice therapists and outpatient (facility-based) providers differed until the 1999 implementation of the BBA provisions regarding these services.

Private practice therapists work outside the administrative or professional control of a facility-based provider, treat patients in their own offices or in patients' homes, and are responsible for their own billing.[8] As of 1999, HCFA redefined its conditions for coverage of private practice therapists, effectively relieving therapy practice owners from having to be on site while licensed therapist employees furnish services (HCFA, 1998c). Under the new regulations, employee therapists, in addition to practice-owner therapists, obtain Medicare provider numbers and use them for billing. This rule change also eliminated the requirement of state survey and certification of private practices, during which surveyors verified that the practices had the necessary equipment to provide an adequate program of services.

In 1996, 6,884 physical therapists and 525 occupational therapists billed Medicare for work done in independent practice. Growth in the number of therapists treating Medicare patients stalled during the mid 1990s, partly because many therapy practice owners became

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[6] Beneficiaries are eligible for SNF Part A benefits if they are transferred to a SNF after a minimum 3-day covered stay in an acute care hospital; if they require skilled nursing care and/or therapy services; and if a physician orders the services. Services are covered for up to 100 days per "spell of illness", and include nursing care; bed and board; physical, occupational, and/or speech therapy; medical social services; and drugs, biologicals, supplies, appliances, and equipment for use in the facility. Custodial care is not covered by Medicare.

[7] Medicare regulations do not recognize speech/language therapists as "private practitioners"— they cannot independently bill the program.

[8] A therapist with an office at a medical institution can be a private practice therapist, but must demonstrate access to necessary equipment and obtain patient referrals from physicians outside the institution.

recertified as rehabilitation agencies, which, unlike therapists, were still paid on a reasonable cost basis and were not yet subject to coverage limits.[9]

Trends in Medicare post-acute expenditures

Until implementation of Medicare's hospital PPS in 1984, post-acute services accounted for a small percentage of Medicare expenditures, and were viewed as a cost-effective alternative to extended hospital stays. Though inpatient hospital care continues to be the most costly part of Medicare, post-acute care is the fastest growing component of the Medicare program. Since implementation of the hospital PPS, Medicare generally has witnessed double-digit rates of annual growth in its post-acute outlays. Between 1986 and 1996 Medicare spending on SNF and home health services— by far the largest components of post-acute care— rose 12-fold, from $2.5 billion to roughly $33 billion.[10] Over 25 percent of the SNF spending reflects therapy payments, and about 10 percent of home health spending reflects therapy (HCFA, 1998d).

Aggregate Medicare spending for therapy and post-acute services in other settings totaled about $8 billion in 1996— including inpatient rehabilitation care, $4.6 billion; long-term hospital care, $1.7 billion; and outpatient therapy and independent therapy, about $1.5 billion. Allowed charges by physical medicine and rehabilitation physicians totaled $344 million in 1996 (HCFA, 1998d; MedPAC, 1998a). (See Table 3). Of those charges, 53 percent ($172.8 million) were inpatient charges and the remaining 47 percent ($153.2 million) reflect other settings.

In terms of recent trends in patient utilization, about 20 percent of beneficiaries are hospitalized each year. Of those, about 12 percent are discharged to SNFs and about 9 percent are discharged home with home health services; about 3 percent are discharged to rehabilitation or long-term hospitals (MedPAC, 1998b). Based on our preliminary data analyses, roughly 10 percent of all beneficiaries use outpatient therapy each year. About 12 percent of these are "post-acute" patients, or were hospitalized within 30 days prior to using outpatient therapy. Approximately 30 percent of all outpatient therapy patients are hospitalized sometime within the calendar year prior to their use of outpatient therapy.

Overall, the post-acute policy issues leading to the BBA included concerns about the aggregate expenditure level, appropriate use, and reasonable payment for the range of Medicare's post-acute services. Of the post-acute settings, growth in therapy outlays was particularly evident, and analyzed, regarding SNFs. SNF therapy trends, in addition to outpatient therapy trends in the ambulatory settings, are described below.[11]

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[9] We are not able to track in the historical OSCAR data recertification of specific private practices to new rehabilitation agencies. Representatives in the therapy community also indicate, though, that this trend occurred.

[10] The expenditure data in this paragraph include program payments and beneficiary coinsurance spending.

[11] Trends in home health therapy are not included here— although home health spending rose steadily in the 1990s, the increase was due mainly to greater numbers of home health users. Further, since 1986, therapy has accounted for a fairly constant share (about 10 percent) of home health payments (HCFA, 1998d). Although home

Therapy in skilled nursing facilities

Throughout the 1990s, Medicare SNF spending rose dramatically— about 33 percent annually. Most of that growth was due to therapy and other ancillaries (such as drugs), rather than growth in room and board rates or in the number of SNF users. In fact during that time, SNF admissions rose only 14 percent per year (MedPAC, 1998a). This growth composition is not surprising since Medicare used per diem rate limits on SNF room and board charges, however ancillary services were not subject to any limits.

Several studies found that both Part A and B therapy spending in SNFs was increasing (for example, Liu, 1993; Marsteller and Liu, 1994; GAO, 1994; GAO, 1996). Liu and colleagues estimated that Part B therapy accounted for about 15 percent of SNF therapy charges. Although much of the therapy was assumed to benefit patients, medical records reviews, often conducted by the Office of the Inspector General of the Department of Health and Human Services (OIG), consistently found that a substantial share of SNF therapy was inappropriate or unnecessary, given Medicare's coverage criteria. In particular, therapy was furnished in many cases where non-skilled or maintenance therapy was more appropriate, and extended or overly-frequent therapy was furnished to patients for whom unrealistic functional goals had been set (for example, OIG, 1998).

Even after the recent implementation of the SNF PPS, concerns remain about the appropriate use of therapy in SNFs. In 1999, for example, the OIG surveyed a random sample of 24 SNFs, reviewing the medical records and bills of 218 Medicare SNF patients. Among these patients, 13 percent of Part A and B therapy services were considered unnecessary by the medical reviewers. In some facilities, over 50 percent of the therapy, as recorded in patient charts, did not meet Medicare's coverage rules. The study also found an additional 4 percent of therapy services billed for but completely undocumented in patients' medical records (OIG, 1999a).

Given Medicare's billing data structure, it is difficult to readily monitor SNF Part A and B outlays, analyze all components of SNF patient care, and identify the type of SNF patient receiving Part B therapy, or outpatient therapy. Until 1999, outpatient therapy could be furnished to SNF patients in four coverage circumstances— current Part A patients; patients who were in Part A stays but then exhausted their Part A coverage; patients in stays not eligible for Part A coverage; and patients not staying or residing in that SNF. The consolidated billing provision implemented in tandem with the SNF PPS in 1999 disallowed outpatient therapy for the first of these patient circumstances.[12] The remaining patient scenarios, and the case-mix

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health agencies also can furnish outpatient therapy (to their non-home bound patients), our preliminary data analyses indicate that this is a negligible amount of total outpatient therapy spending.

[12] The consolidated billing provision requires that virtually all Medicare claims for services delivered during a SNF PPS stay, regardless of whether the service was provided by SNF staff or by providers that contract their services to the SNF (such as a rehabilitation agency), are submitted under Part A by the SNF. Payment for these SNF Part A services is incorporated in the RUGs rates. Like the consolidated billing provision enacted with the hospital PPS in 1984, the measure is intended to secure a full accounting for all charges associated with treating

differences that they might reflect, add to the difficulties in analyzing outpatient therapy in SNFs and comparing with outpatient therapy across settings.

Therapy in hospital OPDs, rehabilitation agencies, and CORFs

Although total SNF therapy outlays are much larger, spending on outpatient therapy in ambulatory settings also has risen steadily. As shown in Table 4, aggregate Medicare payments for therapy to the key ambulatory outpatient therapy providers (hospital OPDs, rehabilitation agencies, and CORFs) rose 18 percent annually between 1990 and 1996, from $350 million to almost $1 billion. Payments to rehabilitation agencies and CORFs grew the most, rising 23 percent and 35 percent per year, respectively.

In 1990, hospital OPDs accounted for over half of non-SNF outpatient therapy outlays, but by 1996 the spending distribution shifted toward rehabilitation agencies and CORFs. In that year, rehabilitation agencies accounted for 55 percent of Medicare outlays for outpatient therapy, and hospital OPDs and CORFs accounted for 30 percent and 12 percent, respectively. While rehabilitation agencies collected the largest share of Medicare payments for outpatient therapy, this share is disproportionate as most outpatient therapy patients use hospital OPDs. In 1996, over two-thirds of outpatient therapy patients used that setting, almost one-third used rehabilitation agencies, and less than 5 percent used CORFs. Other studies have suggested that the higher total payments to agencies and CORFs likely reflect differences in Medicare's payments as much or more than variation in patient diagnosis (HER, 2000; MedPAC, 1998b).

Response to growth: Balanced Budget Act of 1997

The steady increase in Medicare's post-acute outlays catalyzed concern among policy makers that payment for these services may be inefficient and use of these services may be excessive. To rationalize and curb future spending, the BBA required implementation of prospective payment systems for SNFs, home health agencies, and rehabilitation hospitals. The earliest SNFs began transitioning to a PPS in July 1998 (most SNFs began transitioning in January 1999). Prospective payment systems for home health agencies and for inpatient rehabilitation facilities were scheduled to be implemented by October 1999 and October 2000, respectively. (Implementation of the home health PPS later was delayed to October 2000; the rehabilitation PPS is now slated for April 2001.) In addition, the BBRA later required that long-term hospitals transition to a PPS by October 2002.

Just as the acute hospital PPS spurred growth in the use of post-acute care, implementing prospective payment for these post-acute services likely will result in increased use of substitute services, such as outpatient therapy. Although rate-setting payment systems increase providers'

Medicare Part A SNF patients, and for providing incentives to limit the previously unrestrained growth in therapy and other ancillary services. Though implementation was delayed regarding non-therapy ancillaries furnished to SNF Part A patients, consolidated billing for therapy services was implemented when the SNF PPS was implemented.

incentives to furnish care more efficiently, Medicare's experience with these systems has proven that they also create incentives for providers to increase volume or to unbundle services (that is, to shift services that previously were furnished in one setting or time period to other settings or time periods). If inpatient post-acute providers and home health agencies unbundle any of their therapy services (either through shortening patient lengths of stay or furnishing fewer therapy services per stay or episode of care), an increased use of outpatient therapy services and outlays could likely result. This potential circumstance increased the importance of the BBA provisions to end cost-based reimbursement for outpatient therapy services and establish uniform policies across outpatient therapy and private practice therapists. Medicare's existing coverage rules for outpatient therapy would, in theory, be instrumental in curbing any increases in outpatient therapy that would be considered inappropriate or unnecessary. However, numerous OIG audits and reports (cited in the later discussion on policy options) suggest that Medicare's contractors do not appear to enforce these policies effectively. One might doubt whether the existing outpatient therapy coverage policies could adequately protect the program if other post-acute PPSs create incentives for more outpatient therapy service use.

BBA 1997 changes to outpatient therapy policies

Effective January 1999, the BBA replaced the retrospective, cost-based payment policies for outpatient therapy providers with payments based on Medicare's physician fee schedule, and extended the per beneficiary caps already in place for private practice therapists to all non-hospital providers of outpatient therapy.[13]

Since 1974, Medicare has limited its annual coverage of therapy furnished by private practice therapists. Prior to the BBA, those annual limits were $900 per beneficiary for physical/speech therapy, and $900 per beneficiary for occupational therapy. The BBA extended these limits to the non-hospital outpatient therapy providers, and raised them to $1,500 each. Conversations with Congressional committee staff indicate that hospitals were exempted from the coverage limits to help ensure access to outpatient therapy for patients who need substantially more than $1,500 of services. In 2002 and beyond, the coverage limits are to be updated annually by the Medicare Economic Index, or MEI. Beneficiaries are responsible for 20 percent of payments up to the limits (and 100 percent beyond the limits for outpatient therapy furnished in non-hospital settings).

Because of certain computer system limitations of HCFA and its fiscal intermediaries, the coverage limits were implemented for outpatient therapy providers on a facility-specific basis. Thus, a beneficiary who exhausted coverage at one rehabilitation agency or CORF could obtain coverage at a different agency or CORF (in addition to obtaining unlimited coverage at a hospital OPD). However, because of the consolidated billing requirement implemented with the SNF PPS, SNF inpatients could not use multiple providers to obtain multiple outpatient therapy coverage limits the way other outpatient therapy patients could. For example, although it is common practice for SNFs to contract with rehabilitation agencies for therapy services, a SNF could not use in-house therapy staff to furnish therapy up to the limits for a given patient, and then use contracted outpatient therapy services up to the limits. In the same vein, a SNF could not contract with a hospital OPD to furnish unlimited outpatient therapy to the SNF's inpatients (HCFA, 1998a). For private practice therapists, the coverage limits remained in effect on a per-beneficiary basis in 1999. This was possible because of the fact that their services already were subject to coverage limits (and thus the computer mechanisms to track services also were in place).

As evidenced by the 2000-2001 moratorium on the coverage limits, extending the fee schedule to outpatient therapy providers proved to be much less controversial. Historically, Medicare reimbursed both outpatient therapy providers and private practice therapists on a reasonable cost basis, but differences in payment rules emerged in the 1990s. For example, as a

[13] Payments under the physician fee schedule also apply to therapy furnished by hospitals to inpatients who are entitled to benefits under Part A but have exhausted benefits for inpatient services during a spell of illness, and to hospital inpatients not entitled to Part A benefits.

budget savings measure, Medicare began in 1990 reducing most hospitals' payments for all services by 5.8 percent.[14] Beginning in 1992, private practice therapist services were transitioned (along with physician services) to Medicare's physician fee schedule rates. Rehabilitation agencies and CORFs continued to received full, cost-based payments. As an interim savings measure, the BBA required that Medicare reduce payments in 1998 to rehabilitation agencies and CORFs by 10 percent. The 5.8 percent annual reduction still applied to hospital payments. Effective January 1999, all outpatient therapy services are reimbursed using the program's physician fee schedule.

Because the fee schedule is a service-specific payment method, the BBA also required outpatient therapy providers to use a uniform coding system on patient bills to identify the actual services furnished. Minor additions to the HCFA Common Procedural Coding System (HCPCS) were needed to conform with the coding requirement. This provision was slated for April 1998, but was implemented in January 1999.

BBRA 1999 amendments to outpatient therapy policies

During 1999, representatives of outpatient therapy providers, SNFs and some beneficiary groups lobbied policymakers for elimination of the outpatient therapy coverage limits. The representatives argued that the limits were too stringent for patients served by SNFs and that the facility-specific (or per beneficiary per provider) implementation of the limits could disrupt continuity of care for outpatient therapy patients served by rehabilitation agencies and CORFs (for example, McGinley, 1999).

Congress considered alternatives to the coverage limits but ultimately it placed a moratorium on the caps for 2000 and 2001. The BBRA included other outpatient therapy provisions as well. These state that the Secretary must:

- conduct focused medical reviews of outpatient therapy services during 2000 and 2001, with emphasis on claims for services provided to SNF Part B patients;
- study outpatient therapy utilization patterns in 2000 compared to those in 1998 and 1999;
- include functional status (as well as diagnosis, prior service use, and other appropriate criteria) as factors in considering outpatient therapy policies based on patient classification;
- recommend how to apply alternative outpatient therapy policies in a budget-neutral manner; and
- recommend methods for assuring appropriate utilization of outpatient therapy.

[14] Each year since 1990, hospital operating cost payments were reduced by 5.8 percent; capital cost payments were reduced by 10 percent.

Private sector approaches to managing outpatient therapy

As requested by HCFA and to broaden our understanding of overall trends in outpatient therapy coverage and payment practices, we conducted several interviews with a purposive sample of managed care organizations (MCOs) and other relevant health care entities. Our goals included identifying private sector outpatient therapy coverage practices, payment methods, use if any of outpatient therapy practice guidelines or outcome tracking systems, and overall impressions from the insurer or payer viewpoint of outpatient therapy issues. An understanding of private sector outpatient therapy policies, as well as organizations' impressions about the effectiveness of their policies, may be helpful when considering options Medicare could pursue as it shapes its outpatient therapy policies in the future.

Interviews

Our research on the private sector outpatient therapy landscape consisted primarily of telephone interviews with MCOs across the country. We developed a contact list by selecting eight states representing major geographic regions: California, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, and Texas. Within each state, we identified several MCOs with high enrollment rates and selected plans (both health maintenance organizations or HMOs and preferred provider organizations or PPOs) that covered urban and rural populations.[15] The response rate among MCOs was almost 40 percent (13 of 34), and the individuals with whom we spoke were usually medical directors. The medical directors had thorough understandings of their plans' policies, and in some cases had been involved in their development. The interviews consisted of detailed discussions about eligibility, coverage, and payment for outpatient therapy, and broader discussions about outpatient therapy services and policy development. (For examples of questions used to guide the interviews, see Appendix B.) We also interviewed four self-insured plans (both manufacturing and service companies); six large, national Medicare HMOs and two large free-standing rehabilitation hospitals. Confirming and contrasting perspectives offered by these organizations are included in the discussion below. (Summary data from interviews of MCOs and self-insured plans are shown in Table 5.)

In addition to interviewing insurers and outpatient therapy providers, we also researched some of the available medical guidelines and functional assessment tools or outcome tracking systems that are available for outpatient therapy. The extent to which outpatient therapy guidelines and outcome systems are used by insurers is discussed in the section below. Details of the guidelines and outcome systems are described following the MCO interview findings.

Outpatient therapy policies of private-sector health plans

[15] We identified plans using *www.thehealthpages.com* and *The 2000 Guide to Federal Employees Health Benefits Plans.* We collected July 2000 enrollment data from *www.thehealthpages.com*.

Although the private MCOs we interviewed have varying policies for eligibility, coverage, and payment of outpatient therapy, some overarching trends can be identified. In general, most MCOs use similar methods for determining eligibility, although they monitor continued eligibility over the course of treatment to differing extents. Almost all MCOs we interviewed have coverage limits and use similar metrics to define them, but the absolute values of these limits differ between plans. Finally, while many MCOs' outpatient therapy payment systems are based on Medicare's physician fee schedule, other payment methods also are used, such as per visit payment rates.

Like Medicare, most MCOs rely on physicians to determine patient eligibility for outpatient therapy. MCOs monitor continued treatment in different ways than Medicare, however. Rather than require that patients see their referring physicians every 30 days while receiving outpatient therapy, MCOs often allow patients to receive treatment for as many days as prescribed by their physicians. Alternatively, some MCOs monitor eligibility through utilization review— a process by which a staff nurse or therapist reviews initial physician referrals or periodic status updates provided by patients' therapists. Regarding coverage policies, MCOs tend to have fairly specific annual coverage limits. Frequently, MCO annual coverage limits are stated as a number of calendar days or outpatient therapy visits (often, 60 days or 30 visits) beginning from the patient's first visit to a therapist. However, many MCOs are flexible in their coverage limits, and accommodate patients who have more severe conditions. While the MCOs we interviewed do not have either diagnosis-based or outcome-based coverage policies, some MCOs have considered implementing more finely-tuned limits that would allow for better treatment of outliers— that is, patients that appear to need a higher than expected amount of therapy to achieve a reasonable and desired level of function.

Most MCOs currently pay outpatient therapy providers using a variant of Medicare's physician fee schedule. Other MCOs pay outpatient therapy providers on a per visit basis, in an effort to limit incentives for therapists to provide excessive services within a visit. Some capitated MCOs we interviewed "carve out" outpatient therapy services. (That is, the MCOs contract with an outpatient therapy provider or provider network to bear risk for, manage, and furnish outpatient therapy as needed to the health plans' members.) The capitated MCOs seem particularly pleased with their outpatient therapy practice patterns, which they say include a relatively low number of patient visits and equivalent or higher levels of patient satisfaction.

Overall, MCOs with large lines of Medicare business and self-insured plans provide more generous coverage than the initial set of MCOs we interviewed. All Medicare HMOs and most self-insured plans we interviewed do not set specific coverage limits, although they tend to monitor care through more intensive utilization review. The few self-insured plans that do have specific coverage limits are more likely to provide exceptions to their limits. The self-insured plans we interviewed have large shares of retiree members, and appear more likely to cover chronic conditions experienced by their older populations.

At present, many MCOs use published medical care guidelines when determining outpatient therapy coverage. The outpatient therapy guidelines we identified typically were

developed by compiling expert opinion and existing outpatient therapy literature regarding a condition. In general, MCOs use outpatient therapy guidelines to direct utilization review, but do not use them to set coverage limits or devise payment rates by condition. Some MCOs discussed their use, or intended future use, of outcome tracking systems. The outpatient therapy outcome tracking systems we identified collect data from patients or from therapists and billing systems. The systems typically are licensed to outpatient therapy providers, which use the outcome tools to monitor and improve treatment, provide financial incentives for therapists, and develop diagnosis-based estimates of therapy utilization.

Eligibility determination and utilization review practices. The vast majority of MCOs we interviewed require that patients obtain physician referrals prior to receiving outpatient therapy. MCOs that do not require physician referrals commented that their patients almost always visit a physician first of their own accord. MCOs follow various procedures once a patient is referred to outpatient therapy. Some automatically cover the number of visits or "days" (the number of calendar days after the initial therapy visit by which a patient must receive all treatment) recommended by the referring physician, and rely on therapists and physicians to informally communicate patients' status and progress. Other MCOs perform utilization review— they evaluate the physician's referral and the therapist's treatment plan. This review can be either immediate or delayed; if delayed, patients are typically allowed up to six visits before treatment is reviewed. MCO treatment reviewers most often are nurses, although occasionally they are therapists. Most MCOs we interviewed have physicians available on a part-time basis to review more questionable treatment.

Most MCOs we interviewed do not require patients to return to their physicians to remain eligible for treatment, unless specifically requested by the referring physician. Instead, MCOs usually require that therapists provide updates on their patients' progress to referring physicians (by telephone or facsimile). However, this informal communication process is not closely monitored at many MCOs. One MCO we interviewed uses a more continuous, formal approach to monitor eligibility. Under this MCO's regulations, a patient must first visit his or her primary care physician and be evaluated by a therapist. The therapist must then consult with one of the MCO's nurse case managers to develop a treatment plan that is reasonable and effective. The therapist must provide status updates to the case manager every few weeks throughout the course of the patient's treatment. When the case manager determines that the patient's progress is leveling off, the MCO discontinues outpatient therapy coverage.

Like the MCOs, most self-insured plans we interviewed require physician referral for outpatient therapy, and then use various types of utilization review as follow-up. One service-sector employer plan, which tries to have "as few barriers to treatment as possible", has implemented a delayed prior-authorization policy that is similar to that of some MCOs. This plan does not require prior authorization for a patient's first 10 outpatient therapy visits. After that, a patient must call a toll-free telephone number and request authorization from one of the plan's nurse case managers. The case managers have access to the claims data, can ask for additional information from patients, and are responsible for making any follow-up calls to physicians or therapists. For long-term treatment, case managers work directly with therapists, requesting periodic updates about the type of therapy provided, the number of visits, and the

patient's improvement. While not "scrutinizing every visit", the case manager role is designed to ensure that patients receive optimal levels of treatment and prevent the need for costly follow-up visits to physicians.

The Medicare HMOs we interviewed state that they follow Medicare's outpatient therapy coverage policies— namely physician referral, use of treatment plans, and coverage of restorative services. One such HMO explained its process: after a patient has received a physician referral for outpatient therapy, he or she can see a therapist for an evaluation appointment. After the evaluation, the therapist must write-up the patient's baseline prior to injury, the patient's expected baseline following treatment, and a specific treatment plan. The therapist's write-up is then reviewed by the HMO's medical group, which determines whether to authorize treatment. Frequently, the medical group also specifies the interval after which the therapist must send a progress report so that the group can reassess the patient's treatment plan and coverage.

Coverage. Although all MCOs we interviewed essentially use the same process to determine initial patient eligibility for outpatient therapy, they have implemented a wider range of methods for determining how much outpatient therapy to cover. Specifically, MCOs vary in their interpretations of what constitutes an "event", coverage of chronic conditions, and numbers of covered therapy days or visits.

Most frequently, MCO coverage limits are specified as a pre-defined amount of treatment per year or per "event"— with event signifying the onset of an illness or injury that requires outpatient therapy. These coverage limits specify the amount of coverage provided per "episode of care"— with episode referring to the time period beginning with the first outpatient therapy visit (following the initial event) and ending when a patient no longer receives outpatient therapy. Most MCOs define an "event" as a specific diagnosis or range of diagnosis codes, and they consider exacerbations, reinjuries, and surgeries as new events. For example, if a patient suffers a knee injury, undergoes surgery three months later for that knee, and then re-injures the knee four months later, the patient is considered to have had three events, and would be covered for up to the plan's limits for each event. Two of the MCOs we interviewed provide a stricter definition of "event"— while these two plans consider surgery for a previous injury as a new event, they do not view reinjuries as new events.

Coverage of acute, chronic, and maintenance therapy. Only one-third of the MCOs we interviewed expressly cover outpatient therapy for chronic conditions. Several of these particular plans have no coverage limits, while others essentially cover chronic outpatient therapy by granting frequent exceptions to their limits.

The remaining two-thirds of MCOs we interviewed state that they only cover outpatient therapy for short-term episodes. However, these plans vary as to how they define "new" events and when they allow for exceptions to their coverage limits. For example, most of these plans cover exacerbations of chronic conditions, which they consider to be specific, or short-term, events. In contrast, a few of these plans specifically do not cover *any* chronic conditions (for

example, serious back injuries or multiple sclerosis), regardless of whether the patient is experiencing acute symptoms from these conditions. Overall, the self-insured plans cover chronic conditions more frequently than the MCOs.

Most MCOs and all Medicare HMOs we interviewed distinguish between restorative and maintenance therapy, and do not cover the latter. The self-insured plans generally do not cover maintenance therapy, though they are more lenient in their enforcement. Most self-insured plans effectively cover the equivalent of one episode of care for maintenance therapy (for example, if the plan's coverage limit is 30 visits per event per year, the plan will allow up to 30 visits for maintenance therapy annually). Therapy services not covered by most MCOs, self-insured plans, and Medicare HMOs include experimental and investigative treatment, massage therapy, paraffin baths, aquatherapy, and treatment for flat feet.

Annual coverage limits. Most of the MCOs we interviewed have annual coverage limits that are specified in terms of days or visits, or days or visits per event. The most common annual limit is 60 days per event. The limits vary widely, though, ranging from 20 to 60 visits per event per year, or 60 to 120 days per year overall. Other plans cover 60 days per event per year or 60 days solely per event (even if the episode spans two years). Two MCOs have no coverage limits. Several other MCOs offer high-option health plans that include unlimited outpatient therapy coverage.

One of the MCOs we interviewed attempts to manage outpatient therapy expenditures through retrospective provider profiling and education efforts, rather than applying patient-level coverage limits. Case reviewers at this MCO evaluate the outpatient therapy received by patients at the end of the episode of care, and work with the therapists to educate about and ensure the provision of optimal and efficient care.

Self-insured plans we interviewed have similar coverage limits to the MCOs. These plans' respective annual limits are: 20, 30, or 60 visits, and 60 days per event. More so than MCOs, the self-insured plans have flexible limits, which are frequently exceeded if a patient continues to demonstrate functional progress. Members of self-insured plans have an additional level of recourse if denied coverage; if a request for coverage is rejected, a member can first appeal to the plan administrator, and then to the employer's benefits department. From our conversations, it appears that the benefits departments are more lenient than their plan administrators regarding coverage appeals. One self-insured plan we interviewed has no quantitative limit— it covers outpatient therapy as long as it is recommended by the physician and the patient is making specific improvement. Under this plan, therapists must fill out progress forms, and treatment is reviewed and evaluated on a case-by-case basis.

Somewhat mirroring the BBA-mandated outpatient therapy coverage limits, one Medicare HMO we interviewed applied a 60 day per event limit to outpatient therapy providers excluding hospital OPDs, CORFs, and physician-directed clinics. The other Medicare HMOs control service use by monitoring physicians' prescribed number of visits and performing ongoing utilization, but do not have specific coverage limits.

outpatient therapy providers we interviewed confirmed the apparent wide range of coverage limits applied by MCOs. One rehabilitation hospital manages a capitated outpatient therapy network, and thus is able to determine coverage for its patients. Upon seeing a new patient, a lead therapist at this facility conducts an evaluation and develops a treatment plan. Other therapists then take over treatment of the patient. Since this provider is at risk in this instance, it does not have any incentive to furnish an excessive amount of outpatient therapy.

Outliers. Patients in plans with outpatient therapy coverage limits would typically pay out-of-pocket for outpatient therapy consumed beyond the limits. However, some MCOs that have coverage limits provide frequent exceptions to them. At least one medical director would like to move toward diagnosis or condition-based limits in the future. He explained that, at minimum, varying coverage limits for "mild" and "severe" conditions would be more cost-effective while ensuring more adequate coverage of outliers. One MCO we interviewed currently has a formal mechanism for outlier cases. This MCO has identified "targeted diagnoses", which are conditions with "gray endpoints" that are typically not resolved within the plan's coverage limit. A patient with one of these diagnoses is given extended coverage, which is dependent on continued functional improvement, as documented by the therapist and reviewed by the MCO. Similarly, a self-insured plan we interviewed requires regular progress notes from therapists for specific conditions with frequent "gray endpoints", such as stroke, lupus, sprain, contusion, and nerve lesion (for example, carpal tunnel syndrome).

Payment methods. MCOs we interviewed pay for outpatient therapy on a per service basis, a per visit basis, or using a capitated system.

Payment per service. Most often, MCOs pay for outpatient therapy per modality—that is, they pay a separate fee for each outpatient therapy service rendered during a visit. The MCOs we interviewed that pay per service base their rates on the Medicare physician fee schedule, but then adjust their rates for local market and demographic factors. The plans' market penetration plays a role in their rate setting process as well. Further, some plans negotiate rates with each outpatient therapy provider; others just set network and non-network rates. One MCO we interviewed varies its rates by provider performance: individual practitioners are separated into four payment tiers based on how effectively they treat patients.

Many plans pay at rates that are higher than Medicare's fee schedule, and one regional medical director who manages seven mid-east coast states believes that MCOs pay at higher rates than Medicare across most of the nation. In contrast, the MCO with the tiered payment system pays slightly below Medicare rates for its lowest tier (the providers with the least effective performance rating). Another MCO recently lowered its rates by switching from its own fee schedule to the Medicare physician fee schedule.

Payment per visit. About one-third of the MCOs we interviewed use per visit payments for outpatient therapy. In general, it seems that the per visit rates were developed based on

historical visit rates and the average number of services per visit.[16] Several MCOs that pay per service expressed some interest in paying per visit, to remove incentives for therapists to furnish additional (and possibly unnecessary) services. A self-insured plan representative noted that paying per visit also is simpler administratively.

Capitated payment. As might be expected, the capitated plans we interviewed note that they incur fewer outpatient therapy visits per patient, on average. One MCO that uses both capitated and fee-for-service therapists states that, under the capitated system, the average visit count per patient is lower while patient satisfaction is higher. When asked about the satisfaction ratings, the MCO medical director felt that patient satisfaction is higher in their capitated plans partly because patients "have busy lives" and appreciate receiving more patient education while being scheduled for fewer visits. Two of the five capitated plans we interviewed (that are MCOs and Medicare HMOs) carve out outpatient therapy to another organization to manage, bear risk for, and furnish outpatient therapy to the plan's members.

The medical director at a Medicare plan we interviewed also noted the flexibility that capitated plans have in discharge and care planning. For example, she noted that in some cases a longer SNF stay and a shorter episode of follow-up outpatient therapy can be more appropriate. She also stated that capitated arrangements are beneficial regarding outpatient therapy— an area of healthcare she considers as often excessively used.

Rates for private practice therapists and outpatient therapy providers. Most MCOs reimburse private practice therapists at the same rates and using the same methods as they use for (facility-based) outpatient therapy providers. Several other MCOs sign individual contracts with outpatient therapy providers and associations of private practice therapists, and do not have uniform payment rates across their providers. One MCO uses different payment rates for hospital OPDs, other outpatient therapy providers, private practice therapists, and physicians. This MCO pays hospital OPDs according to their costs, which are higher relative to the plan's rates for other outpatient therapy providers and private practice therapists. The MCO pays other outpatient therapy providers and private practice therapists on a per visit basis, with slightly higher rates for the (non-hospital) outpatient therapy providers to compensate for their overhead costs. Finally, this MCO pays physicians on a per service basis using Medicare's fee schedule.

Policy developments. Most MCOs we interviewed have not made significant changes to their payment and coverage of outpatient therapy in the past decade. However, a few have made changes to their systems, including adding periodic treatment reviews by nurses, raising copayment amounts, increasing coverage flexibility for patients with conditions that have "gray endpoints" (as mentioned above), and instituting case manager programs. One medical director commented that outpatient therapy is highly utilized in his area (Louisiana), and MCOs in the area are just beginning to limit outpatient therapy coverage. Another MCO recently ended

[16] One MCO set per visit payment rates 25 years ago based on average costs at that time. This MCO has barely changed payment rates since then— payments have increased only once over the last 25 years. This MCO is currently being sued by outpatient therapy providers to increase their reimbursement rates.

its cost-based reimbursement for hospital OPD providers of outpatient therapy, and began paying them on a per visit schedule— the same model it uses to pays its other outpatient therapy providers. This change is estimated to result in an almost 50 percent reduction in its outpatient therapy payments to hospital OPDs. Two MCOs we interviewed stated that, though they have no specific plans to do so, they would like to see development of a diagnosis and outcome-based payment system, with different limits and goals based on diagnoses and functional status, as well as differential compensation for therapists based on their patients' functional improvement. However, they also expressed concern about the administrative complexity and data burdens of such a system.

Almost all MCOs have used internal historical claims data or their medical staff to develop their outpatient therapy payment policies and specific outpatient therapy coverage limits. While some MCOs have used only these internal resources, over half also have used published guidelines to help determine their outpatient therapy policies. All the MCOs we interviewed that use external guidelines use either InterQual, Milliman & Robertson (also known as MnR), or Apollo guidelines. Some medical directors feel that MnR is significantly less useful for outpatient therapy than for inpatient rehabilitation. According to one medical director, Apollo's outpatient therapy guidelines are more aggressive than InterQual's; his MCO is just beginning to use Apollo in addition to InterQual. In addition to using these guidelines, one MCO also uses HealthSouth's guidelines, which were developed using HealthSouth patient data rather than using expert panels or clinical literature reviews. Most of the self-insured plans we interviewed do not use outpatient therapy guidelines.

Conclusions

Based on our interviews, MCOs use a fairly wide range of policies for outpatient therapy coverage and payment. Although it is difficult to draw conclusions about private MCO payments compared to Medicare payments without a more scientific study, it appears that Medicare might be paying lower rates for outpatient therapy services than most MCOs, on average, but possibly paying for more outpatient therapy services and visits overall. From our interviews, it does not appear that any MCOs have absolute coverage limits, similar to the BBA-mandated $1500 caps. The most promising policy options gleaned from our interviews include the use of annual day or visit limits per event, with provisions for outliers, or patients with more severe conditions. Specifying coverage limits per event allows for adequate coverage for patients who experience multiple conditions throughout the year. Though few MCOs currently have refined coverage limits based on diagnosis or functional status improvement, some plans thought it would be useful to consider diagnosis or outcome-based limits to ensure that patients are receiving the optimal number of visits based on their conditions. Medicare claims data, in addition to information from guideline publishing companies such as Apollo, InterQual, and MnR, and outcome tracking systems such as LIFEware, FOTO, or HealthSouth, could be used in developing such guidelines.

Unlike Medicare— and any traditional fee-for-service insurance plan— most MCOs that we interviewed control their outpatient therapy expenses through some method of utilization review. Many MCOs require prior, delayed, or ongoing authorization for patients to be covered for outpatient therapy, which prevents patients from receiving unnecessary services and ensures that only patients who are making functional status improvements continue to receive services. Almost all MCOs that we interviewed specify maximum annual coverage limits (in terms of number of days or visits per event); these limits are particularly effective for MCOs that pay outpatient therapy providers on a per visit basis because they allow these MCOs to limit the total cost of treatment per event. Other MCOs manage utilization through case managers, who work directly with patients' therapists to determine optimal treatment plans. Finally, some MCOs review treatment after it has occurred, and work directly with care providers to ensure that they are providing the proper amount of treatment. Under Medicare's traditional fee-for-service program, however, no utilization review mechanism explicitly exists to help assess the appropriateness of service use and control expenditures. And, if Medicare simply specified a maximum number of covered visits per event, its expenditures could remain high if therapists increased the number of services provided per visit.

Outpatient therapy guidelines

Over half of the MCOs we interviewed use, in some fashion, medical care guidelines for outpatient therapy. MCOs use them to help determine whether a patient is eligible for coverage, and to direct utilization review during and following treatment. For example, InterQual describes its guidelines as providing a "rule-based nested decision tree". Nurse reviewers can use the tree to determine whether treatment is medically necessary; if the patient matches the

specified criteria, then treatment should be covered. Otherwise, the guidelines recommend that a physician review the patient's records. In this section, we discuss the three major outpatient therapy guidelines used by MCOs we interviewed.

While the major guideline publishing companies have all existed for over a decade, only Apollo began developing guidelines specifically for outpatient therapy prior to 1999. Apollo first published its *Managed Physical/Occupational Therapy and Rehabilitation Care* manual in 1996, as a collaborative effort with HMOs that were interested in reducing what they viewed as physician over-prescription of outpatient therapy services. According to an Apollo representative, the general absence of guidelines for outpatient therapy has helped fuel overuse of these services. MCO demand also spurred the development of other outpatient therapy guidelines: InterQual first published specific guidelines for outpatient therapy in 1999,[17] and MnR publishes only limited outpatient therapy guidelines as part of its workers' compensation guideline product.[18] According to representatives of both companies, the recent expansion of guidelines for outpatient therapy was initiated by MCO requests for these guidelines, as they increased their own focus on outpatient therapy practices and outlays.

Guideline development process. Medical care guidelines are typically developed through an iterative process that integrate experts' opinions with current literature and studies relating to a specific condition. The three guideline publishing companies discussed here develop guidelines using similar processes. First, staff medical experts (and sometimes consultants) conduct literature reviews, identify the possible treatments and practices for a given condition, and write a first draft of guidelines for the condition. The draft is reviewed internally and externally, and revised on an ongoing basis. In addition, clients who use the guidelines often provide comments that are integrated into future versions. Updates are usually made to the guidelines on an annual basis.

In addition to the above process, MnR includes a graded evidence approach in their literature review. MnR classifies their literature into three evidence grades: randomized controlled trials (double-blind); clinical trials (not double-blind); and unpublished studies, expert opinions, and internal studies performed by private organizations (such as MCOs). MnR uses the highest-graded evidence available when developing their guidelines, and specifies the grade of literature used for each aspect of the guidelines.

Guideline formats. Apollo, InterQual, and MnR guidelines are broadly similar in their formats. For a specific condition, the guidelines include a brief overview of the condition, objective and subjective indicators (for example, range of motion and presence of pain), recommended treatment (for example, type of therapy or exercise), and suggested or average numbers of visits. In addition, the guidelines sometimes describe a process to follow if patients

[17] InterQual published *Indications for Rehabilitation & Chiropractic Care* in 1999. This manual was developed from *Indications for Workers' Compensation Clinical Management*, which was first published in 1996.

[18] MnR publishes its outpatient therapy guidelines as part of its Volume 7, *Workers Compensation.*

do not recover sufficiently after the recommended number of therapy visits. For example, if a patient has not recovered within the expected amount of time, a guideline might suggest referring the patient to a medical specialist for further evaluation.

Compared to the other outpatient therapy guidelines, Apollo's guidelines include only a brief description of suggested treatment. However, relative to the other guidelines, Apollo provides the most specific recommendations for the number of visits necessary for each type of condition. Apollo suggests "initial" and "additional" numbers of visits based on diagnosis and level of chronicity. As mentioned, some MCOs consider Apollo's guidelines to be more aggressive than InterQual's, with the former stating lower recommended visits for outpatient therapy.

InterQual guidelines also recommend the number of visits a patient should receive. More so than Apollo, InterQual outlines specific treatment approaches and identifies clear entry and exit points based on specific indicators of patient health and function. For example, for a given patient condition, InterQual's guidelines typically identify the desired therapies and define the necessary intensity and length of care, based upon indicators such as range of motion, the number of hours a patient is kept awake due to pain, and the number of hours per day that a patient can work. These guidelines further specify what level of improvement is expected by the end of the recommended course of therapy. InterQual separates some conditions, such as back injuries, into acute and chronic categories, and varies their guidelines accordingly. InterQual defines a condition as "chronic" if it requires therapy for more than twelve weeks.

MnR's guidelines do not state a recommended number of visits, but rather display statistics indicating the number of days by which the 50^{th}, 75^{th}, and 95^{th} percentile of patients have completed outpatient therapy. According to MnR representatives, their guidelines aim to outline a *process* for providers to follow when developing treatment plans, as well as to provide the prevalence of specific treatment services and, as noted, the statistical distributions on outcome measures. These guidelines also include an analysis of alternative treatments. For example, MnR's guidelines indicate, for a given condition, that range of motion exercises are effective, while ultrasound therapy typically is not. MnR does not separate its outpatient therapy guidelines based on chronicity, but states that it intends to in the future. (And, MnR separates some of its guidelines for other services into acute and chronic categories.)

Guideline modifications. The guideline companies we researched vary in their stance on customer modifications to their guidelines. InterQual does not recommend that customers alter the guidelines, and MnR requires in their licensing agreements that customers altering the guidelines must clearly note their changes in their version of the MnR guidelines. In contrast, Apollo encourages its customers to modify its guidelines.

MnR is in the process of developing a "patient companion" to educate patients about appropriate outpatient therapy usage. MnR has developed similar companions for other services; it plans to release the outpatient therapy patient companion in 2001. MnR expects that its new

patient companion can reduce outpatient therapy costs by educating patients and helping them to continue their therapies in the home.

Functional assessment instruments and outcome monitoring systems

Functional assessment instruments and outcome monitoring systems can be used (in addition to monitoring individual patients) to help analyze and compare clinical practice and patient outcome patterns, identify efficacious and cost-effective treatments, and, possibly, to help develop treatment guidelines and outcome predictions based on specific diagnoses and levels of functional impairment. We interviewed and researched three assessment and monitoring systems that have been developed for outpatient therapy: LIFEware, Focus on Therapeutic Outcomes (FOTO), and a HealthSouth system. (LIFEware and FOTO are the names of outpatient therapy assessment and monitoring systems; HealthSouth, the nation's largest outpatient therapy provider, developed a system using its own patient database.)

LIFEware, FOTO, and HealthSouth's systems each were introduced in the past six years. FOTO was introduced in 1994; HealthSouth's system was developed in 1997; and LIFEware was introduced in 1999. LIFEware and FOTO collect functional assessment data on outpatient therapy patients through their licensees, while HealthSouth collects data from its patient base and six other outpatient therapy providers. In addition to providing outpatient therapy assessment tools for use by therapists, these systems analyze the resulting data and provide each licensee with their own outcome trends in comparison with the outcome trends resulting from the total patient database across licensees. FOTO also offers to physicians information on "best" outpatient therapy providers for a specific condition, as indicated by case-mix controlled patient outcomes in the FOTO database. The systems also are used by their customers to help develop informal lists of best practices and practice guidelines. Unlike the medical care guidelines discussed above, these informal guides result from analyses of contemporaneous patient data and more detailed functional assessments.

Data sources and data content. LIFEware's patient data are collected from about 165 provider licensees, and includes an estimated 22,000 patients (and a total of 70,000 patient assessments). Eighty percent of patients in the database receive outpatient therapy for musculoskeletal conditions; most of the remaining 20 percent are treated for neurological conditions.[19] FOTO's data, also collected from its licensees, includes information from an estimated one-million patients. HealthSouth's system includes data from about 3.5 million patients, primarily representing the provider's own patients.

The outcome systems' content generally is composed of information from health and functional assessments, patient satisfaction, and billing system information. LIFEware and FOTO rely mainly on patient self-rated health and functional assessments; HealthSouth's system relies more on therapists' assessments.

[19] We do not have data to accurately compare across patient populations, but given analyses on Medicare outpatient therapy patients (MedPAC, 1998b), it appears that the prevalence of musculoskeletal and back conditions is relatively lower in the Medicare population, and the prevalence of neurological disorders is somewhat higher.

LIFEware requires a minimum of two functional assessments— an intake and discharge assessment. The system measures and reports patient function along three domains: body movement and control; pain; and mood or psychological state. A single assessment instrument is not used— the system's developers designed a set of assessment tools specific to several major categories of diagnoses or conditions. These tools, which contain patient and therapist-completed sections, relate to the following conditions: musculoskeletal, neurological, multiple sclerosis, comprehensive, and pulmonary. The tools are two to five pages long, and contain the same socio-demographic questions (for example, marital status, primary role, and employment status). The tools differ in the specific functional questions regarding each of the conditions. All forms include identical patient-completed discharge sections that measure patient satisfaction. The assessment tools also contain identical, brief therapist-completed sections specifying patient identification information, as well as onset of illness/injury and evaluation dates. LIFEware representatives state that their instruments were tested and validated on 7,000 patients.

The FOTO system includes data from patients, therapists, and provider billing systems. The system requires self-rated health and functional status assessments to be completed by patients at intake and discharge, and therapists' ongoing assessments of patient function (for example, IADL scores). The system also requires selected billing information to estimate revenue per patient. FOTO originally collected health status information using the Short-Form 36, or SF-36 (a health status assessment instrument developed for the general population).[20] FOTO also originally collected self-rated functional assessments using a set of impairment-specific tools. The developers stopped collecting the additional functional data after finding that it did not yield additional predictive capabilities. FOTO later began using the Short-Form 12 (SF-12), combined with a few items from the SF-36 that assess pain and physical function.[21] FOTO also added its own items related to upper extremity limitations.

Most recently, FOTO used Rasch analysis methods to shorten its patient surveys even further.[22] This analysis method relies on an underlying premise that there are two components shaping an individual's response to a survey item: an individual's actual level of, in this case, health or function, and a survey item's level of difficulty. Rasch analysis involves quantifying the level of difficulty of survey items, and using patient responses to these items to refine the instrument and the resulting assessment. Using this process, FOTO's shortened patient surveys

[20] The Short Form 36, or SF-36, is an assessment form with 36 questions that yield an 8-scale profile of health and health-related quality of life. The instrument has been used in over 750 published studies.

[21] The Short-Form 12, or SF-12, consists of 12 items rather than 36. Validation studies have shown that the SF-12 produces equivalent profiles as the longer SF-36.

[22] Rasch analyses, developed by Georg Rasch during the 1950s through the 1970s, have been used widely to analyze test scores and surveys. Within the rehabilitation industry, Rasch analyses have been used by the Commission on Accreditation of Rehabilitation Facilities (known as CARF), the CanChild center for disability research, and WEMOVE (an information web site that promotes “worldwide education and awareness for movement disorders”).

now consist of a software program that begins with a "medium-difficulty" level question, and continues with questions of increased or decreased difficulty, based on a patient's response to the prior item. LIFEware outcomes also are developed using Rasch analysis methods.

The HealthSouth system's data primarily consist of therapy visit information and functional assessments completed by therapists, in addition to a small set of questions completed by patients at intake. HealthSouth uses five instruments that vary by area of injury. These areas are: hand, wrist, and elbow; spine; knee and hip; foot and ankle; and shoulder. HealthSouth currently is expanding its data collection system. Under the new system, ongoing visit and functional information will be collected, in addition to the original intake and discharge data.

Users and applications. The user base of these three outpatient therapy assessment and outcome monitoring systems include outpatient therapy providers, health plans, workers' compensation programs, and physician groups. LIFEware and FOTO are licensed mainly to outpatient therapy providers, while HealthSouth, being an outpatient therapy provider itself, markets its product mostly to health plans, workers' compensation programs, and physician groups.

LIFEware representatives and other outpatient therapy providers state that the system generally is used as a quality assurance system, both internally and strategically. Providers use it to profile their individual therapists and to compare their staff with other outpatient therapy providers. Providers also use the system to develop best practices that they can communicate to their therapy staff. Some providers use the system to develop financial incentives for their therapists, including bonuses and promotion schedules based on performance. Some providers also use the system in their negotiations with payers.

As with LIFEware, most outpatient therapy providers use FOTO to assess patient outcomes, improve therapists' practices, develop lists of best practices or guidelines, and negotiate outpatient therapy payments with payers. Based on its collected data, FOTO furnishes its users with predictions of the number of necessary therapy visits, therapy intensity, and patient function at discharge. Users can compare and assess themselves in terms of visits furnished, functional improvements, and units of improvement per dollar spent. This last metric is calculated using the net payments expected for each patient, as calculated at discharge using revenue information collected from provider billing systems. The FOTO developers aggregate the revenue estimates and furnish revenue predictions based on patient characteristics. In addition, the FOTO system predicts functional improvement and the necessary number of visits by grouping patients into similar categories based on characteristics such as severity, age, acuity from time of incident, and employment status (FOTO notes that employment status is a strong indicator of number of visits).

outpatient therapy providers with risk-bearing contracts use these systems in their internal utilization review and resource management processes. For example, one outpatient therapy provider has a contract in which it furnishes up to six therapy visits per patient without prior health plan approval. The provider uses FOTO to track patient progress and help determine the

need for additional outpatient therapy. Another inpatient/outpatient therapy provider uses FOTO to help manage resources under the provider's risk bearing contract for a workers' compensation population. This provider uses FOTO to identify factors most affecting their patient outcomes and develop risk assessment and treatment models (in addition to using the system to assess individual patient outcome). As the case-mix composition of the population shifts, the provider also can use their data to negotiate higher payment.

According to HealthSouth, its system is used by health plans and workers' compensation programs to monitor individual patient function before and after therapy and to compare their patients' function, outcomes, and satisfaction to geographic or national averages. This information helps health plans determine the need for additional therapy and helps workers' compensation programs determine when an employee can return to work. MCOs that have capitated and non-capitated products also use the system to compare outcomes, resource use, and satisfaction between enrollees in the two product types. According to their system's data, HealthSouth states that outpatient therapy outcomes between capitated and other plans are comparable, but that satisfaction at the end of treatment is higher among non-capitated plans. (HealthSouth states that it also is initiating surveys to compare satisfaction at the end of therapy and at 30 days after therapy.) As with the other outcomes systems, some health plans use HealthSouth's system to devise classification systems indicating the predicted number of therapy visits, based on patient diagnosis and severity. Plans use these models in negotiating payments with outpatient therapy providers.

Unlike the other outcome systems, HealthSouth also markets its system to physician networks, who can access selected information to help guide their choice of outpatient therapy providers when making referrals for their patients. (HealthSouth states that it strictly limits the information revealed about individual therapists.)

As an outpatient therapy provider, HealthSouth uses its system internally in part to develop its own practice guidelines, including information on preferred therapy methods, expected visit counts, and predicted outcome given a patient's medical characteristics and functional status at initial evaluation. Based on analyses of the aggregate data, the provider aims to identify cost-effective practices and protocols and communicate them to their therapy staff. HealthSouth's system provides a range of expected visit counts, quoted as the 25^{th} to 75^{th} percentile visit counts. The company also uses its system to compare and assess its therapists' patient outcomes, and to target its internal training and education programs. The system is also used in implementing the company's performance-based bonus system and promotion schedule for its therapy staff.

Future applications. LIFEware's developers state that they recently applied for an American Physical Therapy Association grant to study the frequency and intensity of outpatient therapy visits for various conditions, to help identify and quantify cost-effective therapy practices. The developers state that the results likely would be used by the Association to supplement its physical therapy guideline publication, and specifically to add predictions about potential outcomes to the publication. FOTO and HealthSouth representatives state that they are

doing further analyses on outlier patients in their respective databases, in efforts to identify characteristics predictive of this subgroup of patients, and ultimately to improve the outcomes of these patients and the cost-effectiveness of their therapy utilization.

Near-term policy options for outpatient therapy under Medicare

At present, the relatively sparse body of research regarding outpatient therapy practice patterns is not sufficient for designing and implementing an outpatient therapy coverage or payment system based on diagnosis and prior service use by 2002 (when the coverage limit moratorium is set to expire). Further, currently there is no collection of functional status data regarding Medicare outpatient therapy patients that would be sufficient for adequately exploring and developing a functional component for such a system. Indeed, the classification methods and final payment systems that Medicare uses for reimbursing physicians, hospitals, SNFs, and is slated to use for home health agencies and inpatient rehabilitation facilities each were under development for several years (and often a decade) prior to implementation. Even if some aspects of a patient-based outpatient therapy coverage or payment system might ultimately be gleaned from existing systems, considerable work will be necessary.

In the meantime, several technically and administratively feasible options exist for curbing Medicare's rate of growth in outpatient therapy spending. Options include various mechanisms associated with the physician fee schedule; alternative applications of the dollar-based coverage limits; and intensifying and expanding medical review efforts regarding outpatient therapy services.

Components of the physician fee schedule

Several spending control options that Medicare could implement for outpatient therapy tie into the use of the physician fee schedule. A key feature of any of these options is that they apply to growth in payment rates, rather than to the total expenditures of beneficiaries. Thus, under these options, no limits would apply to the amount of therapy payments or number of visits or services covered for individual beneficiaries. To consider these alternatives, it is first necessary to understand the components of the fee schedule.

As required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), a fee schedule replaced Medicare's reasonable charge system for payment for physician services. The fee schedule was implemented in January 1992 and was fully phased in by 1996. Several problems existed with the prior charge-based payment system, including unchecked growth in Medicare's spending on physician services; inequities between payments for services and the resources used in furnishing them; and wide geographic variation in payments. Further, observers noted that under the charge-based system, payments typically did not decline over time for procedures and technologies that, though justifiably costly when first introduced, were less justifiably costly as they were disseminated and integrated into usual practice patterns. As part of the new payment system, limits were also placed on the amount that physicians can bill beneficiaries in excess of the fee schedule rates.

The fee schedule has three main components: a relative value for a service; a geographic adjustment, and a national dollar conversion factor. Updates to the payment amounts are made annually, based mainly on inflation forecasts and on a comparison of actual aggregate physician spending relative to a spending target. Use of this comparison in the update is key to Medicare's attempts to control aggregate outlays for physician services.

Relative value units. The first component of the schedule, the relative value unit or RVU, compares the resources involved in performing one service with that of other services. The relative value for each service is the sum of three sub-components: a work component, which measures physician time, skill, and intensity in providing a service; a practice expense component, which measures average practice expenses (such as office rent and employee wages); and a malpractice expense component, which reflects average costs for professional liability insurance. The proportion of the total RVU that each sub-component represents varies by service.

The work RVUs are based on resource costs and were developed with extensive input from the physician community (for example, Hsiao and Stason, 1979; Hsiao and Becker, 1989). These RVUs are refined and values for new services are added annually; in addition, HCFA conducts a comprehensive review every 5 years. The practice expense and malpractice expense RVUs initially were based on historical charges. Amendments passed in 1994 required the Secretary to develop a resource-based system for practice expense values (these new values are in the process of being implemented); the BBA required that a resource-based system be developed for malpractice expenses.

Geographic adjustment factor. The second main component of the fee schedule is the geographic adjustment factor. In 1997 the geographic areas were revised, reducing the number of areas from 210 to 89. A separate geographic adjustment is made for each of the three sub-components of a relative value unit. That is, there is a work adjustment, a practice expense adjustment, and a malpractice adjustment. These adjustments are made to the three sub-components, which in turn are summed to produce an indexed RVU for each service for each geographic area. As required by law, only 25 percent of the area variation in the work sub-component is taken into account in the actual fee schedule.

Conversion factor. The third main component of the fee schedule, the conversion factor, is a dollar multiplier that converts the geographically adjusted relative value for a service to an actual payment amount. Initially a single conversion factor applied to all services. Later provisions required the use of two conversion factors in 1993 (one for surgical and one for non-surgical services). In 1994 through 1997, three conversion factors applied (one each for surgical, primary care, and other non-surgical services). The surgical conversion factor was the highest of the two or three factors. (See Table 6.) The BBA required the return to a single conversion factor beginning in 1998. The 2000 conversion factor is $36.61.[23]

[23] Anesthesiologists are paid under a separate fee schedule which uses base and time units; a separate conversion factor ($17.77 in 2000) applies.

Annual update to the conversion factor. Annual updates to the fee schedule payments are made by adjusting the conversion factor. The law specifies an update formula, which HCFA calculates (although Congress also can determine the amount). The formula essentially results in an update at inflation plus or minus the cumulative spending growth rate for physician services compared to a target growth rate since a base year. Inflation is gauged using the MEI, which HCFA developed as an annual forecast of the changes in costs of physician time and operating expenses. The update cannot be more than 3 percentage points above or 7 percentage points below the MEI.

The three main components of the fee schedule limit payments per service, but by themselves they do not limit volume and thus overall Medicare spending for physician services. Since the OBRA 1989 legislation, spending growth targets have been used in the update process to help curb Medicare's total outlays for physician services. Until 1998, annual spending growth was measured against targets known as volume performance standards (VPS). Separate standards applied for each conversion factor (surgical, primary care, and nonsurgical). Spending and target comparisons for the second preceding year were used in the calculations. For example, 1997 updates accounted for 1995 spending relative to 1995 targets. Through 1997, the annual targets were estimated after accounting for several criteria that predictably affect Medicare's outlays for physician spending, including:

- inflation;
- changes in the number of Part B beneficiaries in the traditional (fee-for-service) program;
- changes in relevant laws and regulations (such as adding a diagnostic test to the Part B benefit); and
- the average annual change in service volume over the prior 5 years.

This target formula resulted in a growth rate that would be expected to occur if physicians continued to practice as they had previously. The rate then was subject to an automatic percentage point reduction to arrive at the final annual update amount. The automatic reduction amount grew substantially over the years, from 0.5 percentage points under the initial legislation to 4 percentage points by 1997. The final update amount, however, could not be more than 5 percentage points under the MEI.

Students of the physician payment system noted three main concerns related to the VPS target and update mechanism. First, determining separate targets and updates for the three service categories resulted in RVUs in different categories being worth different amounts. Some viewed this as counter to a key principle underlying the fee schedule— that a unit of work should be valued equally across services, regardless of the type of service or physician. Second, the historical service volume measure, in combination with the automatic percentage point

reduction, resulted over time in increasingly stringent targets and subsequently lower updates. This result occurred because the 5-year historical average of service volume growth fell substantially (from 8 percent as applied in 1992, to 2.5 percent as applied in 1997), which led to large increases in the target formula's rates. To curb the high update factors that otherwise would occur, Congress increased the automatic reduction. Third, the VPS mechanism was criticized because update amounts were based on the relationship between spending and targets for 2 years earlier, which does not capture the shortfalls and surpluses that can occur during the intervening year (PPRC, 1997).

Effective in 1999, the BBA replaced the VPS with a new target and update formula. The new formula, termed the sustainable growth rate or SGR, differs from the VPS in four main ways. First, the service volume measure in the prior formula was replaced with a more stable and general indicator of economic growth— projected growth in the nation's real per capita gross domestic product (GDP). Relatedly, the new formula omits the automatic percentage point reduction. Third, the new formula's spending target accounts for cumulative rather than annual spending, so that each year the update is determined after comparing cumulative growth in physician outlays with the cumulative target from a base year (which is 1997). Fourth, the BBA established new maximum and minimum limits— as mentioned above, the annual update factor cannot be more than 3 percentage points above or 7 percentage points below the MEI.

Options related to the physician fee schedule

Options that curb outpatient therapy outlays using the fee schedule affect the payment amount providers receive for individual therapy services. These options do not limit the number or type of therapy services that Medicare would cover for individual beneficiaries at particular settings, as did the coverage limits established under the BBA. These options also do not offer any incentives to limit the number of services that a provider furnishes to an individual patient, as would a payment system based on diagnosis, function, and prior use. Spending control options for outpatient therapy that involve the fee schedule are, however, consistent with policies for other outpatient services furnished by physicians and other non-physician practitioners. Further, these options are technically simple to implement. Fee schedule-based options include:

- applying a non-physician practitioner reduction to fee schedule rates for outpatient therapy;
- using a separate conversion factor for outpatient therapy;
- integrating outpatient therapy services into the volume control system (the SGR) used for other services paid under the physician fee schedule; and
- designing a separate volume control system for outpatient therapy services.

Apply non-physician fee reductions. Currently, four categories of non-physician practitioners reimbursed under the physician fee schedule receive payments that are discounted

from the full scheduled rates. Nurse midwives, for example, are paid 65 percent of the fee schedule amounts for their services. Clinical social workers are paid 75 percent of the scheduled amounts. Physician assistants and nurse practitioners each are paid 85 percent of the schedule amounts. In contrast, two non-physician practitioner categories, certified registered nurse anesthetists and clinical psychologists, are paid 100 percent of the fee schedule amounts. Fee reductions could be applied to non-physician providers of therapy services as well. To determine an appropriate reduction, the amount and intensity of licensed therapy training should be assessed and compared with the training of other non-physician practitioners.

Use a separate conversion factor. Currently a single conversion factor is used in the physician fee schedule, regardless of the type of service or provider. However, there is precedence for applying separate conversion factors based on the overall category of service. As mentioned, two conversion factors were used in 1993, and three were used in 1994 through 1997. In 1997, the amounts of the factors were $40.96 (surgical services), $35.77 (primary care services), and $33.85 (other non-surgical services). The current conversion factor is based on an update of the primary care factor.

Regarding physician services, a main goal of the recent application of a single conversion factor was to further implement the concept of equal valuation of a unit of work. However, other physician fee schedule experts view using several conversion factors as a means to apply volume controls in a more equitable manner (for example, Holahan and Zuckerman, 1993). Multiple conversion factors allow the payment system to target unchecked growth in some service areas while not penalizing payment for services that increase at a more moderate rate. From this standpoint, it would be consistent to consider using a lower conversion factor for outpatient therapy if rapid growth or inappropriate use is a concern.

Applying this option would have almost an equivalent effect as applying a non-physician fee reduction, however the principles underlying the two options differ. The fee reduction option makes distinctions among types of health care providers, while the conversion factor option target types of health care services.

Include therapy services in aggregate volume limits. Applying either or both of the above options to outpatient therapy services, without also applying an aggregate volume control measure, runs the risk of encouraging providers to increase the number of therapy services furnished to recoup their payment rate reductions. This risk is a particular concern in any prospective, or scheduled, payment system that has a very disaggregated unit of payment. (The VPS and SGR mechanisms for physician services respond to this concern; in addition the BBA requires that volume control measures be implemented with the PPS for hospital outpatient services. That PPS uses groups of outpatient services as the unit of payment).

Another option concerning outpatient therapy services, then, is to integrate them into the current SGR volume control mechanism. Alternatively, a separate SGR mechanism could be applied to outpatient therapy services. A primary consideration regarding these two options is the relative outlays between outpatient therapy services (approximately $1.5 billion in 1996,

including independent therapist outlays) and physician services (approximately $55.5 billion in 1996). Because the outlays for physician services are so much greater, they would be the driving influence in an integrated SGR regarding overall service volume trends, relationships between SGR targets and actual spending, and the resulting annual update factors. By contrast, a separate SGR for outpatient therapy services would be more responsive to the practice patterns of therapists. A separate SGR also would allow selection of a base year other than 1997 (the base year under the current SGR system). For example, total outlays for outpatient therapy in 1998 might be lower than 1997 outlays, because the BBA required a 10 percent reduction in outpatient therapy payments that year. Alternatively, the most recent available year may be the best base year, because it would capture any outpatient therapy practice responses to recent changes in the Medicare system, such as the SNF prospective payment system and (depending on the actual implementation date of an outpatient therapy SGR), the upcoming PPSs for home health services and inpatient rehabilitation.

Options using alternative dollar limits

Another set of spending control options for outpatient therapy include alternative applications of the BBA's original dollar-based coverage limits. Numerous options (and combinations of these options) exist, including:

- increasing the two limits (physical/speech therapy and occupational therapy) that existed before the moratorium;
- combining the two limits into a single outpatient therapy limit;
- creating a separate limit for speech/language pathology services;
- setting an outlier pool;
- formalizing the 1999 implementation of the limits (that is, apply them on a per beneficiary per provider basis);
- applying facility-level limits (that is, apply limits to facilities, which then can be averaged across patients in the facilities); and
- exempting particular conditions or combinations of conditions from the limits.

While the fee schedule options directly affect provider payment, most of these alternatives can directly affect beneficiaries. Further, most of these alternatives could be slightly more cumbersome to implement than the fee schedule options. These alternatives likely will be more difficult to implement because, like the BBA coverage limits, most of these beneficiary-level options would require HCFA and its intermediaries to track patient expenditures throughout the year and make the tallies quickly accessible to providers. Two options that are less difficult to track and implement include the "per beneficiary per provider" option and the facility-level

option. Both of these options require each facility to track expenditures for its patients. The former option requires that the limits still apply to each individual, whereas the latter only requires that the limits be met on average, by the facility. That is, a facility-level cap would be established by multiplying an individual "target" limit by a provider's total number of patients per year. Individual patients can be covered for more than the targeted amount, because a provider can average its lower cost and higher cost patients together under its total facility limit.

Prior research offers some indication of the projected impact of the BBA coverage limits and of some coverage limit alternatives. For example, assuming the original per beneficiary interpretation of the limits, an estimated 10 percent of all outpatient therapy patients in the ambulatory settings exceeded either $1,500 of physical/speech therapy or $1,500 of occupational therapy in 1996 (MedPAC, 1998b). When SNF Part B therapy patients are included, that figure reached about 13 percent. Of that share, about one-quarter exceeded the threshold amounts by about $500 or less, and one-half exceeded them by $1000 or less. On the upper end of the distribution, one-quarter exceeded the threshold amounts by $2,500 or more (MedPAC, 1999). Other researchers also projected that 13 percent of outpatient therapy users (in ambulatory settings and SNFs combined) would exceed either of the $1,500 coverage limits in 1999 (Portner et al, 1998).

Simulations of some of the coverage limit alternatives indicate that raising each limit to, for example, $2,000 would result in about 10 percent of all outpatient therapy patients exceeding either of the thresholds. (See Table 7.) Establishing an overall limit of $3,000 would result in about 7 percent of outpatient therapy patients exceeding the limit. Establishing a separate limit for speech/language pathology patients reduces the share of all outpatient therapy patients exceeding any of the limits by about 1 percentage point (MedPAC, 1999). A separate limit for these services has little overall impact because only a small share (about 9 percent) of outpatient therapy patients receive these services; instead, the majority of outpatient therapy patients (about 70 percent) use physical therapy (MedPAC, 1998b).

Two additional options— setting an outlier pool and exempting particular conditions— share a general goal of identifying particularly costly outpatient therapy conditions and effectively offering unlimited coverage for them. Previous analyses suggest that the costliest outpatient therapy patients suffer from stroke, traumatic spinal cord injury, or hip fracture. Approximately 20 to 30 percent of outpatient therapy patients with these conditions exceed $1,500 of physical/speech therapy (HER, 2000; OIG, October 1999; MedPAC, 1999). These conditions in particular would warrant further exploration if condition-specific exemptions were pursued.

Intensified medical review by fiscal intermediaries

Another set of policy alternatives to the coverage limits is to expand and intensify medical reviews of outpatient therapy. At least three government or advisory entities have suggested intensified medical review of outpatient therapy services. The Practicing Physicians Advisory Council (PPAC) recommended focused medical reviews (as well as continuation of the

current coverage limit moratorium).[24] The Council even suggested that "[s]uch a review could lead to the desired budget-neutral outcome [regarding applying alternatives to the $1,500 coverage limits]" (PPAC, 1999). In the BBRA, Congress required HCFA to conduct focused medical reviews of outpatient therapy during 2000 and 2001, with particular emphasis on these services in SNFs. The OIG also recommended more medical review of SNF Part B therapy (OIG, August 1999b). The OIG also recently reviewed a random sample of claims drawn from the five states accounting for almost one-half of outlays to outpatient rehabilitation facilities (ORF is its term for non-hospital non-SNF outpatient therapy providers). The OIG found that one-half of payments were for services that were not sufficiently documented or were considered medically unnecessary. The OIG recommended several actions concerning rehabilitation agencies, with which HCFA concurred. They recommended that HCFA should:

[24] The Practicing Physicians Advisory Council is composed of 15 physicians who are nominated by medical organizations and appointed by the Secretary. The Council meets four times annually to discuss various proposed changes in regulations and carrier manual instructions related to physician services under Medicare.

- "Require FIs to intensify medical review of claims submitted by ORFs"; and

- "Consider a periodic re-certification requirement for ORFs to determine whether or not the facilities remain compliant with Federal and State laws and regulations".

The re-certification recommendation reflects OIG's concern that, whereas many providers have satellite sites in assisted living facilities and SNFs, these additional sites are not required to be surveyed under the state survey and Medicare certification process. Additionally, originally-certified provider sites do not undergo any periodic re-certification. Three other recommendations, aimed at new providers, state that HCFA should:

- "Consider implementing a review process for new providers to include an evaluation of whether the services provided to beneficiaries meet Medicare requirements";

- "Require FIs to provide in-house educational services to new providers to inform them about Medicare coverage, billing, and reimbursement requirements"; and

- "Require FIs to conduct a pre-payment medical review of claims submitted by new providers to determine the appropriateness of the services rendered" (OIG, March 2000).

The first new provider recommendation is meant to augment the initial survey and certification process; the other two require additional efforts by intermediaries once a new provider is certified. The OIG also recommended that HCFA instruct FIs to recover the particular overpayments identified in the process of this study's claims review, review other claims submitted by the facilities in this study, and recover any identified overpayments.

Throughout the 1990s, therapy services were a key focus of the OIG's audits and medical reviews (for example, OIG March 1994, April 1998, August 1999a, August 1999b, October 1999, and March 2000). The reviews generally entail examining and comparing samples of Medicare therapy claims with their corresponding medical records in order to assess the medical necessity and documentation adequacy of the therapy services furnished, estimate the amount of overpayments that Medicare should collect, and make recommendations based on overall findings. SNF Part A and B therapy has been most frequently reviewed; however, rehabilitation agencies and CORFs increasingly are a subject of review. Through the new Medicare Integrity Program,[25] HCFA also is planning for additional, targeted outpatient therapy medical review

[25] The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) included provisions that greatly expanded HCFA's authority and funding ability to contract with entities (in addition to its claims processing contractors) to perform program integrity activities. Through this new initiative (termed the Medicare Integrity Program), HCFA recently has contracted with a pool of entities (which are known as Program Safeguard Contractors) that will perform specific task orders in activity areas such as claims review, medical review policy development, statistical data analysis, provider education, and fraud case development.

activities, outpatient therapy provider education efforts, and exploration of the problems presented by satellite sites and by the lack of any follow-up certification surveys (DeParle, 2000).

Relative to reviewing other Medicare services, targeted outpatient therapy review might be an efficient option given the geographic concentration of outpatient therapy providers. In particular, rehabilitation agencies in six states— Florida, Louisiana, Michigan, New Jersey, Pennsylvania, and Texas— accounted for one-third of all agencies and one-half of Medicare outlays to agencies in 1997. And, as noted above, CORFs are even more concentrated— over one-half (273 of 516) are located in HCFA's Atlanta region (which encompasses eight states) and another 15 percent are found in two states (Pennsylvania, 30 facilities; Texas, 46 facilities). Also as noted, Florida has 35 percent (181 facilities) of the nation's CORFs in 2000.

Longer-term Medicare options based on patient classification schemes

The BBA and BBRA indicated that Medicare's future outpatient therapy policies should be guided by an individual's need for services, as reflected by patient diagnosis, prior use of inpatient and outpatient services, functional status, and any other appropriate and predictive criteria. Ultimately, a patient classification scheme could be used in designing a new payment method to replace the physician fee schedule for outpatient therapy. Alternatively, payments based on the fee schedule could continue and the classification system could be used to help guide outpatient therapy coverage policy.

Under Part B payment policies, Medicare has moved away from cost-based payments typically by developing fee schedules, where providers are paid the lesser of their charges or the scheduled rate for individual services. Examples include the physician fee schedule and the clinical laboratory schedule. Similarly, the hospital OPD payment system currently being implemented uses a fee schedule for groups of related services. Under Part A, however, Medicare generally has developed, or is in the process of developing, payment systems based on larger units of service, and, consequently, based on patient characteristics that predict resource use during the payment period. Payment periods have included the stay (inpatient hospital PPS, the upcoming inpatient rehabilitation PPS, and the future long-term hospital PPS), the day (skilled nursing facility PPS), and 60-day periods of care (the upcoming home health PPS). Similarly, Medicare's managed care payment system is based on predicted annual resource use.

While outpatient therapy is paid on the basis of the service, using the physician fee schedule, a possible future outpatient therapy payment system based on patient characteristics implies use of a more aggregated unit of payment. For example, if most outpatient therapy is furnished on a daily or near-daily basis for varying numbers of days, weeks, or months, a per diem payment unit might be most appropriate. Or, if most outpatient therapy is furnished intermittently for a relatively short period, such as a month or two, the full episode of treatment might be the most appropriate unit of payment. Finally, if most outpatient therapy use is furnished intermittently for a longer period, such as several months, a repeatable (or

recertifiable) 30-day payment unit might be appropriate. However, resources related to some time periods might be adequately predictable regarding most outpatient therapy users, but not so for certain groups. For example, the pattern of outpatient therapy resource use by SNF patients might be substantially different from outpatient therapy users in ambulatory settings. Or, outpatient therapy resource patterns of patients with chronic conditions might be substantially different from those with acute conditions. The outpatient therapy utilization patterns of Medicare beneficiaries must be thoroughly identified and analyzed to determine the time period or periods during which Medicare's resources can be best predicted, given the patient characteristics available for use in the estimations. And, thought must be given to the methods that would best address patients whose resource needs cannot be predicted sufficiently using the predominate unit of payment.

The process above is a highly quantitative and iterative one that draws on the historical patterns of care as identified in Medicare's administrative data bases. It also would be useful, however, to leverage the published and unpublished literature that is available regarding outpatient therapy. A scientific meta-analysis and discussion of the existing literature could provide additional insights and opinions into the most appropriate use and duration of outpatient therapy for various conditions, thus complementing the quantitative Medicare data analyses of the most common use and duration of outpatient therapy. A meta-analysis could involve a review, grading, and discussion of the existing outpatient therapy literature by panels of academic, clinical, biostatistical, and insurance experts. The Patient Outcomes Research Teams, initiated regarding several medical conditions and sponsored by the then-Agency for Health Care Policy and Research, offers one model of such a process.

Ideally, a patient classification development effort for Medicare outpatient therapy patients also would involve a database of functional status assessments obtained during beneficiaries' outpatient therapy service use. Functional status is a key component in other classification systems Medicare uses for prospective payment for therapy services— including the skilled nursing, home health, and inpatient rehabilitation payment systems. Further, functional status is a critical component in the practice guidelines developed for outpatient therapy. Only one group of Medicare outpatient therapy patients— those receiving outpatient therapy in SNFs— are included in a large, readily available database that includes functional assessments. Medicare requires that nursing facility patients be assessed at periodic intervals during their stay using a survey known as the minimum data set or MDS. (Classification of patients for Medicare's SNF payment system also relies on the MDS.) Similar data, however, are not available currently on a large national sample of Medicare patients that is representative of the range of outpatient therapy patient conditions and outpatient therapy providers. To attempt to develop such a database, one might explore the ability to access private databases (such as those of outpatient therapy providers and outcome assessment developers) and merge those systems' Medicare patient data with Medicare claims data. This process would involve numerous challenges. Most significantly, the functional assessment methods would vary somewhat by data source, making it difficult to accurately compare patients across the data sources. Problems in accessing the data and merging them with Medicare claims would be inevitable as well.

Ultimately, a successful classification system satisfies at least five key criteria. First, the system should be clinically coherent— it should be based on an underlying clinical logic relevant to the patient population being classified. This foundation helps guide decision-making during the development process, and helps buoy the system's effectiveness in practice. Second, a patient classification system should produce groups that exhibit relatively little variation *within* groups. This characteristic indicates that the patients within a group are fairly homogenous with respect to the selected outcome measure. This characteristic helps ensure that the ultimate payment rate associated with the group is appropriate for the majority of patients within that group. Third, a classification system also should produce groups with relatively large levels of variation *between* the groups. This indicates that the groups generally are quite distinct from each other with respect to the selected outcome. This also facilitates assignment of patients— that is, identifying the group that is most reflective of a patient's condition. Relatedly, this can make it more difficult for providers to manipulate the classification system for payment purposes by placing a patient in another (higher payment) group. Fourth, the patient assessment and assignment process should be reliable. That is, the process should produce consistent assessments and assignments for a given patient across raters (such as across therapists, nurses, or assessment coordinators and across raters in different settings, including in this case hospital OPDs, rehabilitation agencies, and CORFs). Finally, a classification system should predict a relatively large amount of variation in the selected outcome measure. Policymakers and prospective payment system developers augment the predictive ability of a patient classification scheme by attaching non-patient factors to the scheme that are systematically correlated with variation in the outcome measure. (A classic example of this is hospital teaching status, which is used in the acute hospital PPS and the upcoming inpatient rehabilitation PPS.) Nevertheless, a patient classification scheme that is, by itself, highly predictive of the outcome measure is a critical feature.

It is possible that a patient-based outpatient therapy classification system cannot meet these criteria sufficiently for purposes of provider payment. However, such a system could be modified and still possibly be useful to Medicare in terms of coverage, rather than payment, policy. For example, the system might be predictive of variation in a more broadly defined outcome measure, such as variation in a range of visits used or dollars spent, rather than variation in an exact number of dollars spent (which would be required for use in a payment system). In this case, the physician fee schedule could continue being used for outpatient therapy payment, and the outpatient therapy classification system could function as an empirically-derived norm of Medicare outpatient therapy use. The system could be used by HCFA to assess case-mix controlled variation in Medicare outpatient therapy use by factors such as geographic area or provider type. It also could be used by intermediaries to help make individual outpatient therapy coverage and claim processing decisions. Relatedly, the system could assist in retrospective analyses of coverage and claims processing decisions, outpatient therapy outlays, provider practices, and outpatient therapy patients characteristics and service use.

Workplan

Our quantitative research will aim to provide a wealth of descriptive and analytic information regarding Medicare's outpatient therapy patients, their patterns of care, and the program's aggregate and beneficiary-level outpatient therapy outlays. Key outcomes of this work include:

- providing HCFA with analyses of outpatient therapy spending in 1998 through 2000 (with an emphasis on spending relative to the $1,500 thresholds); and

- providing HCFA with analyses of patients' episodes of outpatient therapy and prior use of services (with an emphasis on findings relevant to a possible future patient-based classification system for outpatient therapy).

Our initial quantitative work is geared toward furnishing HCFA with a report and information in preparation for the agency's June 2000 to Congress concerning outpatient therapy utilization in relationship to the $1500 coverage limits. Our report to HCFA would:

- review the outpatient therapy payment and coverage policies in place each year;

- describe Medicare's aggregate outlays for outpatient therapy by year and provider type;

- analyze annual beneficiary-level outpatient therapy payments relative to the $1500 threshold; and

- further analyze patients with outpatient therapy payments over the $1500 thresholds, including the distribution of payments, for those patients over the thresholds, and the patient and provider factors associated with payments over the threshold.

A two-year (1998-1999) comparison would be conducted initially; a three-year analysis would be submitted after the complete year of 2000 claims are available from HCFA.

The majority of our quantitative analyses will be produced in a final report identifying and analyzing outpatient therapy patients and the episodes of their care. This report would include:

- comparisons of outpatient therapy patients and payments by type of provider and geographic region;

- analyses of demographic and diagnostic characteristics of outpatient therapy patients;

- identification of lengths (or episodes) of outpatient therapy service use; and

- analyses of relationships between outpatient therapy episodes and other Medicare service utilization prior to outpatient therapy.

We will also explore the ability to analyze outpatient therapy patients and their functional status using the Medicare Current Beneficiary Survey. This annual survey of approximately 10,000 beneficiaries includes information on patients' ADL and IADL limitations. Beneficiaries' health and functional status is not assessed at the time of Medicare service use. While that might not pose a problem for analyses of any chronically impaired beneficiaries using outpatient therapy, it would be a concern regarding any outpatient therapy patients whose impairments and functional limitations are ameliorated with a few weeks or months of outpatient therapy.

References

American Hospital Association, *Hospital Statistics,* Chicago: AHA, 2000.

The American Occupational Therapy Association, Inc. Definition of occupational therapy practice for State regulation. *The American Occupational Therapy Association, Inc. Policy Manual (Association Policy 5.3.1)*, July 1994.

American Physical Therapy Association, *Model Definition of Physical Therapy for State Practice Acts, Board of Directors Policies, Positions and Guidelines*, March 1998.

DeParle NA, Agency comment letter to the Inspector General regarding *"Six-State Review of Outpatient Rehabilitation Facilities"*, February 24, 2000.

Department of Health and Human Services Office of Inspector General, *Medical Necessity of Physical and Occupational Therapy in Skilled Nursing Facilities--California Probe Sample Results [Early Alert]*, April 1998.

Department of Health and Human Services Office of Inspector General, *Physical And Occupational Therapy in Nursing Homes: Part B Cost of Improper Billings to Medicare,* August 1999a.

Department of Health and Human Services Office of Inspector General, *Physical And Occupational Therapy in Nursing Homes: Medical Necessity and Quality of Care,* August 1999b.

Department of Health and Human Services Office of Inspector General, *Physical Therapy in Physicians' Offices*, March 1994.

Department of Health and Human Services Office of Inspector General, *Six-State Review of Outpatient Rehabilitation Facilities,* March 2000.

Department of Health and Human Services Office of Inspector General, *Skilled Nursing Facility Therapy Services under Part B of Medicare,* October 1999c.

Health Care Financing Administration, *Consolidated Billing for Skilled Nursing Facilities*," Program Memorandum AB-98-18, April 1998. (HCFA, 1998a).

Health Care Financing Administration, *Medicare Program Manual: Outpatient Therapy Services/Comprehensive Outpatient Rehabilitation Facilities*. Publication No. 9, November 2, 1998. (HCFA 1998b).

Health Care Financing Administration, "Medicare program; revisions to payment policies under the physician fee schedule for calendar year 1999," *Federal Register* November 2, 1998. (HCFA, 1998c).

Health Care Financing Administration, *Health Care Financing Review: Statistical Supplement* December 1998. (HCFA, 1998d).

Health Economics Research, *Comprehensive Outpatient Rehabilitation Facilities Data Analysis*. March 2000. Report under contract to the Health Care Financing Administration.

Holahan J, Zuckerman S, "The future of Medicare volume performance standards," *Inquiry* 30:235-248 (Fall 1993).

Hsiao WC, Stason WB, "Toward developing a relative value scale for medical and surgical services," *Health Care Financing Review*; 1(2):23-38 (Fall 1979).

Hsiao WC, Becker ER, "Paying physicians according to their resource-costs: the development of a resource-based relative value scale," *Health Policy*; 12(3):257-61 (1989).

Liu, K. *Therapy Services Provided to SNF Patients under Medicare Part B*. May 1993. Report under contract to the Health Care Financing Administration.

Marsteller, Jill A. and Liu, K. *High-end Therapy Patients: How Many and How Much?* November 1994. Report under contract to the Health Care Financing Administration.

Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book,* Washington, DC: MedPAC, July 1998a.

Medicare Payment Advisory Commission, *Report to the Congress: Context for a Changing Medicare Program,* Washington, DC: MedPAC, June 1998b.

Medicare Payment Advisory Commission, *Outpatient Therapy* briefing tables for Congressional committees and HCFA, summer 1999.

McGinley L. "Medicare caps for therapies spark protests*," Wall Street Journal*, April 26, 1999, pg. B1+.

Physician Payment Review Commission, *Annual Report to Congress, 1997*. Washington, DC: PPRC, 1997.

Practicing Physicians Advisory Council, *Report Number Thirty-One to the Secretary of DHHS Practicing Physicians Advisory Council,* December 13, 1999.

Portner G, Muse DN, Nystrom SC, *An Analysis of Rehabilitation Services Flow Patterns and Payments by Provider Setting for Medicare Beneficiaries, 1996*. Report for the National Association for the Support of Long Term Care (Alexandria, VA, July 1998).

US General Accounting Office, *Outpatient Rehabilitation Therapy Caps*, October 8, 1999.

US General Accounting Office, *Overuse of Therapy Services in Nursing Homes*, August 1996.

US General Accounting Office, *Tighter Rules Needed to Limit Overcharges for Providing Therapy to Nursing Home Residents*. November 1994.

Appendix A

List of States by HCFA Region Assignment

This appendix lists U.S. states and territories by their HCFA region assignment. These regions were developed based on the locations of HCFA's regional offices and their geographical jurisdictions.

Boston

- Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

New York

- New Jersey, New York, Puerto Rico, Virgin Islands and Canada

Philadelphia

- Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia

Atlanta

- Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee

Chicago

- Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin

Dallas

- Arkansas, Louisiana, New Mexico, Oklahoma and Texas

Kansas City

- Iowa, Kansas, Missouri and Nebraska

Denver

- Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming

San Francisco

- Arizona, California, Hawaii, Nevada, American Samoa, Guam and North Mariana Islands

Seattle

- Alaska, Idaho, Oregon and Washington

Appendix B

Interview Questions for Managed Care Organizations

A. Type of health plan

- What type of plans do you offer? (For example, HMO, PPO, point-of-service.)

B. Eligibility determination

- How do you determine if a patient is eligible for outpatient therapy services?
- Do you use a gatekeeper, case manager, or other type of utilization review staff for outpatient therapy?
- How frequently does an outpatient therapy patient need to see this staff person (or how frequently does the outpatient therapy patient's case need to be reviewed) to continue receiving outpatient therapy services?

C. Coverage

- Are there any outpatient therapy services that you typically do not cover?
- Do you cover exacerbations of chronic conditions? Do you cover maintenance therapy?
- Do you have a maximum limit of coverage per patient per year? Per episode?
- What is your definition of episode? Event?
- Do you have a maximum payment limit?

D. Payment methods

- How do you determine how you will pay for outpatient therapy services?
- Do you pay per visit, per service (or therapeutic modality), or per patient (capitated system)?

E. Private practice therapists versus outpatient therapy facilities

- Do your reimbursement methods or rates for therapists in private practice differ from those for outpatient therapy facilities? Do your methods or rates differ among different types of outpatient therapy facilities?

F. Policy development

- Do you use any formalized guidelines to help determine outpatient therapy coverage (or payment) rules?
- How have you developed these guidelines? (For example, have you used any medical management guidelines, such as those by Milliman & Robertson? Did you use internal resources and data to develop your own guidelines?)

G. Any changes in policy

- Have you made any major changes to your coverage or payment policy for outpatient therapy services, or do you plan to? (If so, what are the changes, and why were they made?)